☐ HEALTH CARE
FLEXIBLE SPENDING ACCOUNT
CLAIM FORM

RECEIVED:_____

DOCUMENT #:_____

USE A DEPENDENT CARE CLAIM FORM FOR DEPENDENT CARE EXPENSES

_____ _____ _____
Employee Name Employee # Work Ext. #

_____ _____ _____
R.C. Name R.C. # Home Phone #

List of Expenses – please itemize your qualifying expenses on the lines provided below. If additional space is required, please use another Health Care FSA claim form.

Date Incurred:	Services Provided:	Out of Pocket Expense*:
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____
_____	_____	$_____

*Out of Pocket Expense equals: 1) City Plan – scheduled allowed amount minus payment amount on the Explanation of Benefits, 2) Qualifying FSA expenses not covered under the Employee Benefit Trust.

Spouse and Dependent Information (if expenses were for your spouse or dependent):

_____ _____
Spouse/Dependent's Name/Date of Birth/Relationship Spouse/Dependent's Name/Date of Birth/Relationship

_____ _____
Spouse/Dependent's Name/Date of Birth/Relationship Spouse/Dependent's Name/Date of Birth/Relationship

A dependent is your spouse, child or other person for whom you may take a deduction under I.R.C. Section 152.

I certify that the expenses listed above have been incurred by me and qualify for reimbursement from the FSA account. These expenses have not been reimbursed, and are not reimbursable under any other health plan coverage. These expenses will not be claimed as a deduction on my personal income tax return or any other individual's FSA account. The bills, receipts, explanation of benefits or other evidence of the expenses are attached.

_____ _____
EMPLOYEE SIGNATURE DATE

Mail or Return to:
City of Mesa
Flexible Spending Account
P.O. Box 1466
Mesa, AZ 85211-1466

Revised 5/13/09